| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15K101 | A. BUILDING _____ B. WING _____ | 02/01/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ELDER'S JOURNEY HOME CARE LLC | 4211 E 3RD STREET BLOOMINGTON, IN 47401 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| G 000 | INITIAL COMMENTS<br><br>This was a federal home health recertification survey, This was a standard survey<br><br>Survey dates: January 25 -February 1, 2016<br><br>Facility Number: 012972<br><br>Medicaid Provider #: 201126900<br><br>Census: Skilled: 69<br>Aide Only: 51<br><br>Home visits: 5<br>Clinical records reviewed: 10<br><br>Elder's Journey Home Health was found to be in compliance with home health regulations (42 CFR 484), no deficiencies were cited. | G 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE